No. 95-1340

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

HUGHES AIRCRAFT COMPANY,

Petitioner,

v.

UNITED STATES EX REL. WILLIAM J. SCHUMER,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Brief *Amicus Curiae* of National Health Law Program, Inc. in Support of Respondent

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INTEREST OF *AMICUS CURIAE*

The National Health Law Program ("NHeLP") is a national public interest firm that seeks to improve health care for America's working and unemployed poor, minorities, elderly and people with disabilities. NHeLP serves legal services programs, protection and advocacy offices, community-based organizations, the private bar, providers, and individuals who work to maintain a health care safety net for the millions of uninsured or underinsured low-income people. NHeLP monitors Medicare, Medicaid and other publicly-funded health care programs, seeks remedies when laws and policies are ignored, and helps Americans receive needed medical care.

NHeLP has an interest in preserving the integrity of Medicare, Medicaid and other Government-funded health care programs.

Medicare is the nation's largest single payer of health care costs. In 1994, Medicare spent $162 billion, or 14 percent of the federal budget, on behalf of about 37 million elderly and disabled Americans. About 90 percent of Medicare beneficiaries obtain services on an unrestricted fee-for-services basis. Patients choose their own physicians or other health care providers, and the resulting charges are sent to the program for payment. The Health Care Financing Administration ("HCFA") within the Department of Health and Human Services is Medicare's health care buyer. HCFA contracts with private companies across the country like Blue Cross and Blue Shield, Aetna and Travelers to process and pay Medicare claims.[1]

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[1] U.S. Gen. Acct. Off., *Medicare: Modern Management Strategies Could Curb Fraud, Waste and Abuse* 1-2 (GAO/T-HEHS-95-227, 1995).

Medicaid is the nation's major publicly-financed health and long-term care insurance program for low-income Americans. Medicaid is cooperatively funded and administered by Federal and State Governments. In fiscal year 1995, Medicaid provided health care coverage for about 40 million low-income people. Over the past 10 years, Medicaid expenditures have more than tripled to $159 billion.[2] In response to budgetary pressures, increasing numbers of Medicaid recipients have been required to enroll in "managed" health care benefits plans.[3] The decided trend in these managed care arrangements is for Medicaid to pay health care plans a preset amount and expect the plan to provide the Medicaid services that are needed by the recipients.

Both Medicare and Medicaid are susceptible to widespread fraud by insurers, physicians, hospitals, and other members of the health care industry. The effects of this fraud ripple through the health care system:

> When federal programs are exploited and abused, it not only costs the taxpayers more, but also may diminish public support for programs, deprive eligible beneficiaries of benefits, and lower the level of services provided.[4]

The loss of hundreds of millions of dollars annually as a result of false and fraudulent billing of Government by health

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[2] U.S. Gen. Acct. Off., *Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care* 3 (GAO/HEHS-96-184, 1996).

[3] *Id.* at 1 (As of June 1995, 11.6 million Medicaid beneficiaries--32 percent of all Medicaid beneficiaries--were enrolled in managed care plans.).

[4] U.S. Gen. Acct. Off., *Federal Agencies Can, and Should, Do More to Combat Fraud in Government Programs* 11 (GAO/GGD-78-62, 1978).

care providers and contractors threatens both the financial viability of these Government-funded health care programs and the quality of medical services, and thus places at risk those Americans who rely on Medicare or Medicaid for their health insurance and medical needs.

The False Claims Act has proven to be an effective tool in ferreting out false and fraudulent billing practices in the health care industry and in enabling the Government to recover significant dollars whose loss would ultimately be borne by the American taxpayer.

Although the facts in this case involve defense procurement fraud, this Court's decision could have implications in other areas of government contracting, including the health care industry.[5] NHeLP's *amicus curiae* brief explains how the amended FCA and its *qui tam* provisions serve as an effective

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[5] Indeed, the Brief for *Amici Curiae* "Healthcare Associations" suggests that if this Court interprets the "public disclosure" issue broadly as requested by Petitioner, then a hospital might be able to prevent its employee from becoming a *qui tam* relator if the employee learns about fraudulent claims from an audit performed at the Government's direction. *See* Brief for *Amici Curiae* The Association Of American Medical Colleges, The American Hospital Association, And The American Medical Association In Support Of Petitioner, at 4-5, 19-20. The Healthcare Association's interpretation of the "public disclosure" bar would turn that jurisdictional bar on its head because virtually all audits, reports and other self-monitoring of claims under Medicare, Medicaid and other Government-sponsored health care programs are required by or done at the request of the Government. The practical effect of the Healthcare Association's broad interpretation of the "public disclosure" bar would be to leave health care providers and contractors to police themselves regarding the submission of claims to the Government. Such a situation would be tantamount to leaving the fox to guard the hen house.

means to eliminate the fraud that permeates Medicare,[6] Medicaid[7] and other Government-funded health care programs.

In recognition of NHeLP's interest in this case, the parties have consented to the filing of this brief.[8]

SUMMARY OF THE ARGUMENT

The False Claims Act, with its *qui tam* provisions, is an effective litigation tool that is essential to our nation's fight against the unlawful submission of false or fraudulent claims to the Government by, among others, health care providers and contractors.

At the time the Act was amended in 1986, procurement fraud in the defense industry was pervasive. As the Act succeeded in combating at least some of the excesses of defense

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[6] False or fraudulent claims to the Government under the Medicare program are remedied under the FCA. *See* S. Rep. No. 345, 99th Cong., 2d Sess. 21, *reprinted in* 1986 U.S.C.C.A.N. 5200 [hereinafter Senate Report] ("false Medicare claims have been uniformly held to be within the ambit of the False Claims Act, though the claims were actually filed with and paid by insurance companies") (citing with approval *Peterson v. Weinberger*, 508 F.2d 45 (5th Cir.), *cert. denied*, 423 U.S. 830 (1975)).

[7] Although federal involvement in Medicaid is less direct than Medicare, claims submitted to state agencies under Medicaid are subject to civil enforcement actions under the FCA. *See* Senate Report, *supra*, at 22 (citing with approval *United States ex rel. Davis v. Long's Drugs, Inc.*, 411 F. Supp. 1144 (S.D. Cal. 1976)). For background information on the rise of fraud and abuse in Medicaid, *see* Paul Jesilow *et al.*, *Prescription For Profit: How Doctors Defraud Medicaid* (1993).

[8] Letters of consent from both parties have been filed with the Clerk of the Court.

procurement fraud, the focus of civil enforcement actions by the Government and *qui tam* relators by the mid 1990's shifted from the defense industry to the health care industry.[9]

False and fraudulent billing of Government by health care providers and contractors has reached epidemic proportions. Although the Government pays nearly one trillion dollars annually for health care, including its funding of programs such as Medicare and Medicaid, it has few, if any, effective institutional controls to detect false and fraudulent claims.[10] Similarly, States lack resources and regulations to police health care fraud.[11]

The False Claims Act and its *qui tam* provisions are needed to effectively detect and prosecute the rampant false and fraudulent billing of Government by health care providers and contractors. Every citizen has an interest in remedying and deterring the submission of false or fraudulent claims to the Government because each of us pays in one way or another for tax dollars that are paid to health care providers and contractors.

Fighting fraud does more than simply uphold the integrity of the public fisc. It also has tangible, positive effects on the everyday lives of the beneficiaries of Government programs such as Medicare and Medicaid. Recovering funds unlawfully

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[9] *See* Dep't. of Justice, *Justice Department Recovers Over $1 Billion in Qui Tam Awards And Settlements* (DOJ 95-542, Oct. 18, 1995).

[10] *See infra* notes 22-26 and accompanying text.

[11] *See* U.S. Gen. Acct. Off., *Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources* 6-7 (GAO/HRD-94-26, 1993); *infra* note 26.

taken from these programs enables more Americans to receive health insurance coverage and medically necessary services.

The United States Court of Appeals for the Ninth Circuit correctly ruled that damage to the public fisc is not an essential element of a *qui tam* action under the FCA.[12]

Accordingly, this Court should affirm the judgment of the Court of Appeals.

ARGUMENT

A. Congress Intended The 1986 Amendments To The FCA To Strengthen The Rights Of Citizens To Report And Prosecute False and Fraudulent Claims To The Government

1. Fraud Against The Government Was A Serious Problem Before The 1986 Amendments To The FCA

In 1981, the United States General Accounting Office produced a three volume Report to Congress entitled *Fraud In Government Programs: How Extensive Is It? How Can It Be Controlled?*[13] The Report concluded: "Fraud against Government programs is widespread. It undermines the integrity of Federal programs and makes people lose confidence

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[12] The "Argument" Section of this brief does not address the retroactivity and public disclosure issues.

[13] U.S. Gen. Acct. Off., *Fraud in Government Programs: How Extensive Is It? How Can It Be Controlled?* (GAO/AFMD-81-57; GAO/AFMD-81-73; GAO-AFMD-82-3, 1981) [hereinafter Report or GAO Report I, II or III].

in public institutions." GAO Report I, *supra*, at cover sheet. Among those identified as responsible for the fraud were federal contractors and grantee employees. *Id.* at 7. False statements were second only to theft as the largest type of fraud identified by the GAO Report. GAO Report II, *supra*, at 2.

The study found that nearly all false statement cases related to five agencies: the Social Security Administration, the Department of Defense, the Veterans Administration, the Department of Agriculture, and the Department of Housing and Urban Development.[14] *Id.* at 3. The Report noted that fraud permeated Government programs. *Id.* at 8-15 (citing a range of fraud against Government involving welfare and food stamps benefits, defense procurement, crop subsidies and disaster relief).

The GAO Report explained that the total cost of fraud could never be known because so much fraud goes undetected. GAO Report I, *supra*, at 4-5.[15] The GAO Report stated that "[t]he sad truth is that crime against the Government often does pay." *Id.* at cover page. Unlike violent crime, where the evidence of illegal conduct is shockingly apparent, fraud is much more subtle. It is concealed by lies and often is cloaked in the legitimacy of an on-going corporate or public concern. *See* Richard A. Posner, *Economic Analysis of Law* 221 (1992).

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[14] Notable by its absence at the time was the Department of Health and Human Services, which oversees the Medicare and Medicaid programs. As explained on pp. 12-22, *infra*, since the early 1990s, the health care industry has increasingly become the focus of enforcement actions under the FCA.

[15] *See also* Senate Report, *supra*, at 2.

Although the exact dollar cost of false and fraudulent claims to the Government could not be calculated with certainty, the United States Department of Justice estimated in 1981 that "fraud [w]as draining 1 to 10 percent of the entire Federal budget." Senate Report, *supra*, at 3. Such a projection meant at the time that "fraud against the Government could be costing taxpayers anywhere from $10 [billion] to $100 billion annually." *Id.*

Before the 1986 Amendments to the FCA, fraud in Government-funded programs often went undetected or unremedied because the Government itself suffered from bureaucratic gridlock and insufficient resources; and because the citizenry was not effectively empowered to compel the Government to take remedial action. Congress observed at the time that:

> [T]here are serious roadblocks to [the Government] obtaining information as well as weaknesses in both investigative and litigative tools. . . . Detecting fraud is usually very difficult without the cooperation of individuals who are either close observers or otherwise involved in the fraudulent activity. Yet in the area of Government fraud, there appears to be a great unwillingness to expose illegalities. . . . [T]he collection of information which leads to successful fraud recoveries is hampered by Government's inadequate investigative tools.

Senate Report, *supra*, at 4-6; *accord* H.R. Rep. No. 660, 99th Cong., 2d Sess. 18 (1986) [hereinafter House Report] ("GAO found that due to weak internal controls and the fact that Government auditors do not pay adequate attention to possible fraud, many fraud cases have gone undetected.").

2. Congress Responded To Rampant And Unremedied Fraud Against The Government By Amending And Strengthening The FCA And Its *Qui Tam* Provisions

In 1986, Congress amended the FCA, including its *qui tam* provisions, to improve the effectiveness of Government and its citizens to prosecute false and fraudulent claims to the Government. Senate Report, *supra*, at 1.

The *qui tam* amendments eliminated the overly restrictive jurisdictional bar preventing *qui tam* lawsuits about which the Government possessed certain information, 31 U.S.C. § 3730; entitled successful *qui tam* relators to at least 15% and up to 30% of the funds they help recover from the defendant, *id.* § 3730(d); required the defendant to pay for the successful relator's reasonable costs of suit and attorney's fees, *id.*; permitted relators to maintain their status as parties to the FCA case even if the Government intervened in the case, *id.* § 3730(c); and established protections from employer retaliation for employee whistleblowers. *Id.* § 3730(h).

The effects of these changes were threefold. First, they removed the key barriers that had previously prevented citizens from filing *qui tam* suits against wrongdoers.[16] Second, they affirmatively encouraged people with knowledge of FCA violations to come forward to vindicate the Government's

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[16] *See* Senate Report, *supra*, at 25-26 (giving *qui tam* plaintiffs a more direct role in the litigation serves as a check that the government does not neglect evidence, cause undue delay, or drop the false claims case without legitimate reason); *id.* at 24 ("[M]uch of the purpose of the *qui tam* actions would be defeated unless the private individual is able to advance the case to litigation.").

rights.[17] And third, as a result, they increased the deterrent effect of the Act.

A "rational" wrongdoer contemplating whether to commit fraud weighs the potential payoff from fraud against the likelihood and consequences of being caught.[18] The revitalized *qui tam* provisions are available to any of the "rational" wrongdoer's peers, co-workers or others who know of the unlawful conduct and want to right it. The incentives for these people to right the wrong have been sufficiently strengthened by the 1986 Amendments, thus increasing the likelihood that a wrongdoer will be caught. In addition, the 1986 Amendments to the Act increased the potential loss to a wrongdoer from being caught by exacting treble damages and requiring the wrongdoer to pay the relator's fair costs and attorneys' fees. For the "rational" wrongdoer, the potential payoff from fraud is more likely to be outweighed by the higher likelihood of being caught

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[17] *See* House Report, *supra*, at 23 ("The purpose of the *qui tam* provisions of the False Claims Act is to encourage private individuals who are aware of fraud being perpetrated against the Government to bring such information forward.").

[18] *See generally* Robert Cooter & Thomas Ulen, *Law and Economics* 506-32 (1988). Judge Posner, in his book *Economic Analysis of Law*, writes:

> A growing empirical literature on crime has shown that criminals respond to changes in opportunity costs, in the probability of apprehension, in the severity of punishment, and in other relevant variables as if they were indeed the rational calculators of the economic model. . . .

Richard A. Posner, *Economic Analysis of Law*, 223-24 (1992).

and the larger potential loss from being found liable. Thus, under conventional economic theory, the rejuvenated *qui tam* provisions make it less likely that a "rational" wrongdoer will commit fraud. It was Congress' intent that its 1986 Amendments have this effect, *cf.* Senate Report, *supra*, at 2, 8, and the courts should enforce the statute consistent with the remedial purpose of the Act.

3. The Amended FCA And Its Revitalized *Qui Tam* Provisions Have Proven Effective In Fighting Fraud By Those Who Contract With Or Bill The Government

One way to measure the effectiveness of the 1986 Amendments is to compare the number of FCA *qui tam* cases filed and the total dollars recovered in those cases prior to and after the Amendments.

Although information on the subject is limited, one study reports, based on Justice Department records, that between 1943 and 1986, there were only three *qui tam* cases filed under the FCA with total recoveries of $54,000.[19] According to another source, *qui tam* lawsuits numbered six or fewer annually prior to 1986.[20]

Since the 1986 Amendments to the Act, the Government has recovered over three *billion* dollars in civil fraud actions,

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[19] William Stringer, Kalorama Consulting Group, Inc., *The 1986 False Claims Act Amendments: An Assessment Of Economic Impact* 23 (1996).

[20] Paul Reidinger, *Fraud Doctors*, ABA Journal 49, 52 (May 1996).

and more than one *billion* dollars of those recoveries are attributed to 153 *qui tam* cases.[21]

False and fraudulent billing of Government has been going on at least since President Lincoln's time. *See* Senate Report, *supra*, at 8. Yet, only since Congress amended the FCA and its *qui tam* provisions in 1986 has Government, with the substantial assistance of an empowered and proactive citizenry, been able to effectively prosecute and deter billing fraud in any sustained, meaningful and measurable way.

B. The FCA And Its Revitalized *Qui Tam* Provisions Are Needed To Fight False And Fraudulent Claims To The Government In The Health Care Industry

1. The Health Care Industry Is Highly Susceptible To False And Fraudulent Claims To The Government By Health Care Providers And Contractors

The Government spends about one trillion annually on health care for its citizens.[22] Funding for Medicare and Medicaid accounts for many of those dollars.[23] However,

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[21] *See* Dep't. of Justice, *Justice Department Recovers Over $1 Billion In Qui Tam Awards And Settlements* (DOJ 95-542, Oct. 18, 1995).

[22] *See* Senator William S. Cohen, Investigative Report of Minority Staff of Senate Special Committee on Aging, *Gaming The Health Care System* 7 (July 7, 1994) [hereinafter Investigative Report].

[23] *See, e.g.*, U.S. Gen. Acct. Off., *Medicare: Rapid Spending Growth Calls for More Prudent Purchasing* 3-4 (GAO/T-HEHS-95-193, 1995). For fiscal year 1994, federal spending on Medicare totaled $162 billion, or $440 million per day. *Id.* at 1. In March 1995, the Congressional Budget Office

relatively few Government dollars are spent policing health care fraud and abuse. For example, less than one quarter of one percent of Medicare dollars is spent auditing payments by the Government.[24] Rather than increase the percentage of processed claims reviewed for billing fraud, HCFA has actually decreased the percentage from 20% in 1989 to 5% in 1994,[25] while the number of claims submitted for processing has gone up annually.[26]

Managed care is contributing to the Government's inability to effectively police health care fraud. Medicaid increasingly relies on capitated, risk-based managed health care plans to

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estimated that these expenditures would approach $350 billion by 2002, and exceed $460 billion by 2005. *Id.*

Controls placed on Medicare spending in one sector of the health care industry create pressure to increase spending in other sectors. For example, between 1992 and 1993, as diagnosis-related group cost containment measures limited Medicare reimbursements to hospitals for in-patient stays and treatment, there was a concomitant increase in Medicare spending for outpatient services, home health agencies and nursing homes. *See* U.S. Gen. Acct. Off., *Medicare: High Spending Growth Calls For Aggressive Action* 3 (GAO/T-HEHS-95-75, 1995).

[24] U.S. Gen. Acct. Off., *Medicare: Reducing Fraud And Abuse Can Save Billions* 5 (GAO/T-HEHS-95-157, 1995).

[25] *Id.* at 7.

[26] *Id.* at 3-5, 7.

The States are not better positioned than the Federal Government to fight health care fraud and abuse because the States are under-funded and lack sufficient experienced manpower to do the job. *See* U.S. Gen. Acct. Office, *Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources* 6-7 (GAO/HRD-94-26, 1993).

serve program beneficiaries. The managed care plans and their networks of providers are paid preset amounts of money per member per month, and they, in turn, agree to provide each Medicaid member with health care as called for in the Government contract and as needed by the patient. However, because the plans are being paid on a capitated basis, claims often are not submitted to the Government purchaser who might otherwise verify that a required service was in fact rendered. Thus, in the managed care context, the Government is losing access to encounter and claims data that it has traditionally relied on to police health care fraud and abuse.[27] While much of the movement toward managed care has focused on Medicaid, the Medicare program is increasingly using similar purchasing and delivery arrangements.

Rising health care spending by the Government and decreasing administrative surveillance for billing fraud enhances the opportunity and incentive for billing fraud and abuse by health care providers and contractors.

With so much Government money at stake in the health care industry, and so few institutional controls on how those dollars are spent, Government-funded health care programs have become highly susceptible to false and fraudulent billing. A 1992 Report by the General Accounting Office predicted that fraud and abuse would consume 10%, or about *$100 billion*, of the Government's *annual* health care expenditures.[28] A Senate Report two years later confirmed those figures and noted that

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[27] *E.g.*, Health Care Financing Admin., Dep't of Health and Human Services, *Integrating EPSDT and Managed Care* 6 (1996).

[28] U.S. Gen. Acct. Off., *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse* (GAO/HRD-92-69, 1992).

"[o]ver the last five years, estimated losses from these fraudulent [health care] activities totaled about $418 billion--or almost four times as much as the cost of the entire savings and loan crisis to date." Investigative Report, *supra*, at 1. That Report characterized health care fraud as "rampant," and warned that "[a]s our health care system moves toward a managed care model, opportunities for fraud and abuse will increase. . . ." *Id.* at 32.

Health care fraud and abuse has compromised the quality of and coverage for health care delivery for many Americans.[29] One Government study concluded:

> [P]atients--and, in the case of Medicare and Medicaid, taxpayers--pay a high price for health care fraud and abuse in the form of higher health care costs, higher premiums, and at times, serious risks to patients' health and safety.

Investigative Report, *supra*, at 1. For example:

* a home health care company billed Medicaid for millions of dollars of health care services by aides who were *un*trained and *un*qualified to provide those services;[30]

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[29] *See* U.S Gen. Acct. Off., *Federal Agencies Can, and Should, Do More to Combat Fraud in Government Programs* 11 (GAO/GGD-78-62, 1978) ("When federal programs are exploited and abused, it not only costs the taxpayers more, but also may diminish public support for programs, deprive eligible beneficiaries of benefits, and lower the level of services provided.").

[30] *See* Investigative Report, *supra*, at 2.

- 1500 employees lost prescription drug coverage because a pharmacist's fraudulent billing of Medicaid and a private insurer artificially inflated the cost of insurance to prohibitively expensive levels for their employer;[31]

- many nursing home patients and pharmacy customers unknowingly received ineffective samples or expired prescription drugs from a pharmacy that billed the Government for the drugs;[32]

- patients received expired or reused pacemakers, and mislabeled pacemakers intended for "animal use only," as part of a kickback scheme involving cardiologists, surgeons and a pacemaker salesman;[33] and

- a physician who examined patients with hypertension falsified their blood pressure readings and failed to treat their disease though he billed Medicaid hundreds of thousands of dollars for supposedly treating these and other patients suffering medical maladies.[34]

False and fraudulent billing in the health care industry manifests itself in many forms, including: overbilling; billing for

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31 *Id.*

32 *Id.*

33 *Id.* at 2, 16.

34 *Id.* at 22.

services not rendered; collecting capitation amounts but not providing the service called for in the managed care contract; "unbundling" (billing one item as many separate component parts); "upcoding" services to receive higher reimbursements; paying kickbacks and inducements for referrals of patients; falsifying claims and medical records to certify an individual for Government benefits; and billing for "ghost" patients or "phantom" services. Investigative Report, *supra*, at 1.

2. The *Qui Tam* Provisions Of The FCA, As Amended, Are An Effective Litigation Tool To Combat False And Fraudulent Claims To The Government By Health Care Providers And Contractors

The FCA and its *qui tam* provisions, as amended by Congress in 1986, already have proven effective in policing and prosecuting procurement fraud in the defense industry.[35] With fraud and abuse "rampant" in the health care industry,[36] the amended Act should likewise be an effective litigation tool for Government and its citizens to combat false and fraudulent claims to the Government by health care providers and contractors.

By all indications, the collaborative effort between the Government and its citizens to ferret out false and fraudulent claims in the health care industry is working. *Qui tam* lawsuits

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35 *See* statistics on successful procurement fraud prosecutions and recoveries under the amended FCA in Dep't of Justice, *Justice Department Recovers Over $1 Billion in Qui Tam Awards And Settlements* (DOJ 95-542, Oct. 18, 1995).

36 *See* Investigative Report, *supra*, at 32.

under the FCA have been responsible for the Government recovering:

- $3.1 million from a clinical laboratory which, over a five-year period, billed Medicare for local mileage charges for transporting specimens 5.7 million miles, equivalent to 230 trips around the earth;[37]

- $182 million from a laboratory testing company that billed Medicare for tests never performed;[38]

- Millions of dollars that hospitals or physicians collected based on improper referrals or forged Medicare claims;[39]

- Millions of dollars from medical equipment and drug companies that overbilled the Government or falsely represented to the Government the nature of the products or supplies being sold;[40]

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37 U.S. Gen. Acct. Off., *Medicare: High Spending Growth Calls for Aggressive Action* 6 (GAO/T-HEHS-95-75, 1995).

38 Office of Inspector General, Dep't. of Health & Human Services, *Laboratory Corporation of America to Pay $187 Million to Resolve Charges of False Claims to Government Programs* (Nov. 21, 1996) ($182 million civil liability plus $5 million criminal fine).

39 *See* Office of Inspector General, Dep't. of Defense, *Semi-Annual Report to the Congress* (Oct. 1, 1994 - Mar. 31, 1995).

40 Dep't. of Justice, *Medical Supplier Pays U.S. $4 Million To Settle Fraud Case* (DOJ 96-288, June 19, 1996); Dep't. of Justice, *Health Care Fraud Report FY 94* (1994); Rafael Alvarez, *Company Settles False Claims Case: Firm Accused Of Billing Medicare High Prices For Cheap Equipment,*

- $1.86 million from an ambulance service for dialysis patients who supposedly were confined to their beds but in fact could walk;[41]

- $39.8 million from a laboratory testing company that billed Medicare for tests that were not reasonable and necessary for the diagnosis or treatment of an illness or injury;[42]

- $40.35 million from insurers who mishandled or submitted improper or false billing to Medicare;[43] and

- Millions of dollars from physicians, home health operators, and nursing home facilities who falsely billed Medicaid for services not rendered or improperly performed.[44]

Baltimore Sun, Oct. 3, 1995, at 2B.

41 Dep't. of Justice, *Health Care Fraud Report FY 94.*

42 *United States ex rel. Dowden v. MetPath, Inc.*, No. 91-1843, 1993 WL 397770 (C.D. Cal. Sept. 13, 1993).

43 *United States ex rel. Flynn v. Blue Cross/Blue Shield of Michigan*, L93-1794, 1995 WL 71329 (D. Md. Jan. 10, 1995); *United States ex rel. Burr v. Blue Cross and Blue Shield of Florida, Inc.*, No. 91-134-Civ-J-16, 1992 WL 521775 (M.D. Fla. Aug. 4, 1993); Dep't. of Justice, *Health Care Fraud Report FY 94* (1994); *Massachusetts Insurer To Pay $2.75 Million To Settle Fraud Case*, Wall St. J., Sept. 29, 1994, at B12.

44 Dep't of Justice, *Albuquerque Psychiatrist, Hospital Settle With U.S. For $700,000* (DOJ 96-214, May 8, 1996); *Doctors Reach Settlement*, Washington Post, July 26, 1996, at B6; *$875,000 Settlement In False Claims Case*, N.Y.L.J., Dec. 26, 1995, at 2, *as corrected by* N.Y.L.J., Dec. 28, 1995, at 2; *HMO Settlement Should Encourage Others To Expose Medicaid Fraud,*

The foregoing examples are merely a small percentage of the false and fraudulent billing that plagues Medicare, Medicaid and other Government-funded health care programs.

The Government's recent recovery of $182 million from Laboratory Corporation of America ("LabCorp") illustrates how effective the FCA *qui tam* provisions can be in ferreting out false and fraudulent billing to the Government in the health care industry.[45] LabCorp marketed packages of blood tests for doctors who billed their patients directly at one price, and unbundled those packages and charged Medicare separately--and at a substantially higher price--for each test in the bundle, including some tests that routinely were not performed.[46] Because physicians never saw the LabCorp statements sent to third-party payers like Blue Cross and Blue Shield, they did not know about the false and fraudulent billing. The relator, a physician, used LabCorp for blood tests required for his practice. He noticed that LabCorp commonly did tests that he neither needed nor wanted for his patients and thus became suspicious of its billing practices. He reported his suspicions to the Government, and reportedly was told by one official not to concern himself with the problem because Medicare was paying the bills.[47] Ultimately, the doctor filed a *qui tam* complaint

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Sun Sentinel, Nov. 9, 1996, at 14A; *see generally* Investigative Report, *supra*, at 21-25.

45 *See supra* note 38 and accompanying text.

46 *See* Elyse Tanouye, *Laboratory Corp. Nears Accord In Medicare Case*, Wall St. J., Nov. 21, 1996, at A2.

47 *See Whistle-Blowers Get Cut Of Funds*, Greensboro News & Rec., Nov. 26, 1996, at B2; Richard McKay, *LabCorp Defends Settlement Over Billing*, Greensboro News & Rec., Nov. 23, 1996, at A1.

under the amended FCA and his action (and the lawsuits of three other relators)[48] forced the Government to take remedial action.

Remarkably, in 1992, LabCorp's predecessor, National Health Laboratories Corporation, paid the Government $111.4 million in a *qui tam* case after pleading guilty to submitting false and fraudulent claims for medical tests.[49]

The enormous amount of money that Government pays to health care providers and contractors has created a tremendous incentive not just for laboratory testing companies like LabCorp, but for insurance companies, physicians, durable medical equipment providers, hospitals and countless others in the health care industry, to risk filing false and fraudulent claims to the Government because of the potential lucrative financial return. That misguided economic opportunity and incentive will be deterred only by strong and certain economic and legal consequences.[50] The 1986 Amendments to the FCA provide the needed counterbalance.

The health care industry has become in the 1990s what the defense procurement industry was in the 1980s--an industry without conventional controls to police and prevent false and fraudulent claims to the Government, yet an industry that is pervasively dependent upon Government funding for its

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48 *See Whistle-Blowers Get Cut Of Funds*, Greensboro News & Rec., Nov. 26, 1996, at B2.

49 *See* Richard Turner, *National Health Labs Pleads Guilty To Fraud, Agrees To Pay $110 Million*, Wall St. J., Dec. 21, 1992, at A2.

50 *See supra* note 18 and accompanying text.

existence.[51] Just as the amended FCA, with its strengthened *qui tam* provisions, was essential to reigning in the billing abuses of defense contractors in the 1980s, so too is it necessary to controlling the fraudulent billing excesses of health care providers and contractors in the 1990s and beyond.

C. Consistent With The Remedial Purpose Of The 1986 Amendments, Injury To The Public Fisc Is Not An Essential Element Of A Cause Of Action Under The FCA

Injury to the public fisc is not an essential element of an action under the FCA. The Senate Report accompanying the 1986 FCA Amendments explains that "[t]he United States is entitled to recover [civil penalties] solely upon proof that false claims were made, *without proof of any damages*." Senate Report, *supra*, at 8 (italics added) (citing *Fleming v. United States*, 336 F.2d 475, 480 (10th Cir. 1964), *cert. denied*, 380 U.S. 907 (1965)).

In cases pre-dating the 1986 Amendments, this Court has consistently recognized that injury to the public fisc is not an essential element of an FCA claim. For example, in *United States ex rel. Marcus v. Hess*, 317 U.S. 537 (1943), this Court affirmed a district court ruling that the Government's discovery of the fraud in time to withhold payment from the defendant did not bar a claim under the Act. Later, in *Rex Trailer Co. v. United States*, 350 U.S. 148 (1956), this Court relied on its decision in *Hess* in holding that specific damages need not be

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[51] For example, federal funds pay for 41% of hospital care, 32% of nursing home care, and 28% of doctors' fees. *See* Bureau of the Census, *Statistical Abstract of the United States* 98 (tbl. 137) and 100 (tbl. 141) (1992).

demonstrated to recover under the Surplus Property Act. And in *United States v. Neifert-White Co.*, 390 U.S. 228 (1968), this Court stated that the FCA, which it characterized as a "remedial statute," *id.* at 233, "reaches beyond 'claims' which might be legally enforced, to all fraudulent attempts to cause the Government to pay out sums of money." *Id.*

Nothing in the 1986 Amendments alters this precedent.

The submission of false or fraudulent claims to the Government by health care providers and contractors, even if not paid by the Government, erodes the integrity of Government-funded health care programs. *See, e.g.*, Senate Report, *supra*, at 3 ("Even in the cases where there is no dollar loss . . . the integrity of quality requirements in procurement programs is seriously undermined."). When the quality of these programs is undermined, the Government and its taxpayers ultimately bear the costs. *See* Investigative Report, *supra*, at 1; *supra* notes 4 & 29 and accompanying text.

CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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